

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2011
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NAME OF PROVIDER OR SUPPLIER

ETOWAH HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**409 GRADY ROAD, PO BOX 957
ETOWAH, TN 37331**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An annual Recertification survey and complaint investigation #27025 and #27888 were completed on April 20, 2011. No deficiencies were cited related to complaint investigation #27888 under 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited related to complaint investigation #27025.

F 157
SS=D 483.10(b)(11) NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update

F 000

F 157

DISCLAIMER: "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth of the statement of deficiencies. This plan is prepared and/or executed solely because it is required."

[Signature] 5/3/11
Administrator Date

F 157
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

No corrective action can be taken for Resident #13; Resident #13 expired on 2/25/2011 due to complications related to diagnosis of Huntington's Chorea

5/27/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] NHA

5/3/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER ETOWAH HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331		
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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to notify the physician for a change in condition and a responsible party's request for transfer to the hospital for one resident (#13) of twenty residents reviewed.</p> <p>The findings included:</p> <p>Resident #13 was admitted to the facility on October 17, 2007, with diagnoses including Pleural Effusion, Seizure Disorder, Huntington's Chorea, and was discharged to the hospital on October 26, 2010. The resident was readmitted to the facility on November 3, 2010, and expired on February 25, 2011.</p> <p>Medical record review of s nurse's note dated October 10, 2010, revealed "...Temp: 97.6...Family reported to (staff) a sore on resident (right) foot. On assessment resident has open area on (right) great toe, 0.5 cm (centimeter) (and) 2nd toe 0.02 x 0.1 red inflamed area...Notified (named physician)..."</p> <p>Medical record review of a physician's order dated October 10, 2010, revealed "Clean on (right) foot areas (right) great toe (and) 2nd digit knuckle (with) NS (normal saline) apply betadine daily until healed."</p> <p>Medical record review of a nurse's note dated October 11, 2010, revealed "...Temp: 97.5...tx</p>	F 157	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Current residents of the facility have the potential to be affected by the same deficient practice. The Director of Nursing will provide in service education to the licensed nursing staff on May 13, 2011 on the importance of notifying the primary care physician with any changes in condition. Nurse managers will conduct an audit of current resident charts reviewing the last 60 days of nurse's notes for proper physician notification of any changes in condition. Nurse managers will review the 24-hour report and telephone orders for any significant changes in resident's condition. The nurse managers will compare the findings on the 24 hour report to that of the documentation in the medical record for proper physician notification.</p>		5/27/11

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F 157	<p>Continued From page 2</p> <p>(treatment) cont (continues) to (right) foot 2nd digit (toe) red (and) inflamed...1130 (named physician) notified of right second toe warm to touch swollen, red, tender to touch, ulcerated area on knuckle. No new orders at this time...12:30 p.m. (named physician) returned call N/O (new order) Septra DS...BID (twice a day) per tube x 7 days..."</p> <p>Medical record review of a physician's order dated October 12, 2010, revealed "...D/C (discontinue) Septra (new order) Cipro 250mg (milligrams) 1 per tube BID..."</p> <p>Medical record review of a nurse's note dated October 18, 2010, revealed, "...Temp 98.9...antibiotic conts (continues) for infection to toe. (Responsible party) (named) here this shift. Very upset about resident's toe. Stated...wanted (resident)...sent to the hospital because (antibiotic) wasn't enough. Explained to (responsible party) that all the hospital could do was the same thing we were doing..."</p> <p>Medical record review of a nurse's note dated October 22, 2010, revealed "...Temp: 97.0... (responsible party) (named) here this shift. Upset re (regarding) infection of toe. After checking toe again area is completely covered (with) thick flaky scab. One small (less than) 0.5 cm white blister beside scab. Area drained upon touching. (responsible party) upset wanting resident sent to hospital. After explaining to (responsible party) the toe had improved greatly, (responsible party) cont to insist on sending (resident) to hospital... (responsible party) then left facility quickly...DON (Director of Nursing) notified by phone of occurrence..."</p>	F 157	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. The Director of Nursing will provide inservice education to the licensed nursing staff on May 13, 2011. In-service education will include the importance of physician notification with any change in condition and documenting any changes in condition in the 24-hour report. A posttest will be given after the inservice to promote competency. 2. New employees will receive education on physician notification and updating the 24-hour report with any changes in resident's condition during their orientation period. 	5/27/11	

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F 157	<p>Continued From page 3</p> <p>Medical record review of a nurse's note dated October 26, 2010, revealed "... (responsible party)...here at present. Conts to be upset re (right) foot 2nd digit. States it is still infected. Insist on sending (resident) to the ER (emergency room) call placed to (named physician). (new order) send to (named hospital)..."</p> <p>Medical record review of the hospital consultation report dated October 26, 2010, revealed "...Date of Consultation: 10/31/10...The patient has developed a chronic wound on the toe during the past few months...subsequently treated with local wound care...the patient has continued not to improve. The patient eventually had wound culture which turned up methicillin-resistant Staphylococcus aureus...had a bone scan which was positive for osteomyelitis on 10/29/10...was moved to the hospital and started on IV (intravenous) antibiotics...Treatment/Plan...The patient will most likely not heal with IV antibiotics due to the significant contracture of the toe...recommend surgical amputation of the second toe right foot...will try to schedule patient, if family agrees, for this Thursday for amputation...deferred by (responsible party)..."</p> <p>Review of facility policy, Physician Notification revealed "...Notify the primary care physician of any changes in condition..."</p> <p>Interview on April 19, 2011, at 9:30 a.m., with the Director of Nursing, in the Social Services office, confirmed no documentation the physician had been notified of the (responsible party's) request to send the resident to the hospital on October 18 and October 22, 2010, or the change in condition of the toe on October 22, 2010.</p>	F 157	<p>3. The charge nurses will notify the primary care physician with any change in condition. Changes in condition/new orders will be documented in the resident's chart and also in the 24-hour report. The 24-hour form will contain a column where the licensed nurse will document that proper physician notification has occurred. The charge nurses will review the 24-hour report at shift change with the oncoming shift to alert them of any changes in condition, new orders received, or any follow-up required.</p> <p>4. The Nurse Managers will review the 24-hour report for any additional follow up/physician notification required. Any deficient findings will have corrective action taken at the time of discovery.</p>	5/27/11

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F 157	Continued From page 4	F 157		
F 280 SS=D	<p>C/O #27025</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two (#1, #5) of twenty residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on October 27, 2010, with diagnoses including Peg Tube Placement (feeding tube), History of Throat Cancer, History of Prostate Cancer, and Skin</p>	F 280	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing /Assistant Director of Nursing will perform random monthly audits of the 24-hour report for physician notification/follow-up. Audits will continue monthly times 3 or until substantial compliance has been achieved. Trends, patterns, or problems identified will be reviewed in the Quality Assurance meeting held at least on a quarterly basis.</p> <p>DISCLAIMER: "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth of the statement of deficiencies. This plan is prepared and/or executed solely because it is required."</p> <p><i>[Signature]</i> 5/3/11 Administrator Date</p>	5/27/11

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F 157 Continued From page 4

F 280 C/O #27025
SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO
PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to revise the care plan for two (#1, #5) of twenty residents reviewed.

The findings included:

Resident #1 was admitted to the facility on October 27, 2010, with diagnoses including Peg Tube Placement (feeding tube), History of Throat Cancer, History of Prostate Cancer, and Skin

F 157

F 280

280
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

The care plan of Resident #1 was updated to include an interdisciplinary approach to address grief related to the loss of his spouse and his own health concerns. A problem addressing grieving was added to the care plan of Resident #1 along with interventions to assist the resident with coping with the loss of his wife and his own health related concerns. The care plan of Resident # 5 was updated to reflect the physician's order stating resident is to be NPO at all times. The interventions on the care plan were updated as well to reflect that resident is unable to have a water pitch at bedside or have any fluids by mouth.

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F 280

Continued From page 5
Cancer.

Medical record review of the resident's current care plan revised on January 23, 2011, revealed no interventions for grieving, due to history of Cancer, or the spouse of the resident's recent admission to the facility due to decline in health and recent death.

Interview with the resident and family member on April 18, 2011, at 9:50 a.m., in the resident's room revealed the resident's spouse had passed away during the week prior. Interview with a family member revealed the resident's spouse was admitted to the facility a "...couple of months ago..." to be near the resident and while at the facility the spouse's health declined and passed away.

Observation on April 18, 2011, at 1:35 p.m., April 19, 2011, at 8:35 a.m., 12:55 p.m., in the resident's room, revealed the resident "resting" and exhibiting red rimmed eyes.

Interview on April 20, 2011, at 11:10 a.m., in the social services office with the Director of Nursing and the Licensed Practical Nurse working as the Acting Social Worker, confirmed the resident's current care plan did not address the resident's grieving process.

Resident #5 was admitted to the facility on November 5, 2010, and readmitted on April 10, 2011, with diagnoses including Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Bronchitis, Diabetes Mellitus, and Dysphagia.

Medical record review of a physician's order

F 280

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All current residents have the potential to be affected by the same deficient practice. In service education will be provided to the Interdisciplinary Team/Care Plan Team by the Director of Nursing by May 13, 2011 on the importance of updating care plans that reflect current physician's orders and appropriate interventions that are personalized to each individual resident based on their condition. A review of current care plans will be completed by the Interdisciplinary Team to review that current physician's orders and interventions are being addressed appropriately and accurately.

5/27/11

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F 280	<p>Continued From page 5 Cancer.</p> <p>Medical record review of the resident's current care plan revised on January 23, 2011, revealed no interventions for grieving, due to history of Cancer, or the spouse of the resident's recent admission to the facility due to decline in health and recent death.</p> <p>Interview with the resident and family member on April 18, 2011, at 9:50 a.m., in the resident's room revealed the resident's spouse had passed away during the week prior. Interview with a family member revealed the resident's spouse was admitted to the facility a "...couple of months ago..." to be near the resident and while at the facility the spouse's health declined and passed away.</p> <p>Observation on April 18, 2011, at 1:35 p.m., April 19, 2011, at 8:35 a.m., 12:55 p.m., in the resident's room, revealed the resident "resting" and exhibiting red rimmed eyes.</p> <p>Interview on April 20, 2011, at 11:10 a.m., in the social services office with the Director of Nursing and the Licensed Practical Nurse working as the Acting Social Worker, confirmed the resident's current care plan did not address the resident's grieving process.</p> <p>Resident #5 was admitted to the facility on November 5, 2010, and readmitted on April 10, 2011, with diagnoses including Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Bronchitis, Diabetes Mellitus, and Dysphagia.</p> <p>Medical record review of a physician's order</p>	F 280	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. The Director of Nursing will provide in-service education to the Interdisciplinary Team/Care Plan Team by May 13, 2011 on the importance of updating care plans that reflect current physician's orders and appropriate interventions that are personalized to each individual resident based on their condition. A post test will be given after the in-service to promote competency. 2. New employees participating in the care planning process will receive education during their orientation period on updating the care plan with any new orders or interventions needed to accommodate needs. 	5/22/11

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F 280	Continued From page 6 dated April 10, 2011, revealed "...Glucerna (tube feeding formula) 240 ml (milliliters) bolus feeding every 4 hours via PEG (Percutaneous Endoscopic Gastrostomy) tube..." Further review of the physician telephone order dated April 12, 2011, revealed "...ST (Speech Therapy) eval (evaluation) completed. ST to Tx (treat) 3 x wk/4 wks (three times per week for four weeks) Continue pt (patient) on NPO (nothing by mouth)..." Medical record review of the care plan updated April 6, 2011, revealed "...encourage fluids with all accepted food related activities and when visiting in room...encourage po (by mouth) fluids with meals, hydration passes and prn (as needed)...keep water pitcher within reach..." Observation on April 18, 2011, at 12:25 p.m., and April 19, 2011, at 3:55 p.m., revealed the resident in the room with no food or water pitcher present. Interview with Registered Nurse #2 on April 18, 2011, at 3:58 p.m., in the Minimum Data Set office, confirmed the care plan had not been updated since the April 10, 2011, readmission to address the NPO status.	F 280	3. The MDS Coordinators will review the care plans of residents they are assigned to by the Director of Nursing. Care plan updates will be conducted Monday-Friday with updates from the weekend completed on the following Monday. The updates will include adding new physician orders from the previous day to the care plan and any interventions needed to address changes in condition. They will update the care plans based on current physician orders and interventions that are appropriate to that resident based on their overall condition.. The other members of the Interdisciplinary Team will review the care plans for appropriate interventions that comply with physician orders. . Any deficient practice identified by the members of the Interdisciplinary Team will have corrective action taken at time of discovery. 4. During morning report, the Interdisciplinary Team will review current telephone orders and the 24 hour report for any significant changes in condition that would warrant a care plan update. Care plans will be updated at this time.		8/27/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, laboratory data review, laboratory calendar review, and interview, the facility failed to	F 281			

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F 280	Continued From page 6 dated April 10, 2011, revealed "...Glucerna (tube feeding formula) 240 ml (milliliters) bolus feeding every 4 hours via PEG (Percutaneous Endoscopic Gastrostomy) tube..." Further review of the physician telephone order dated April 12, 2011, revealed "...ST (Speech Therapy) eval (evaluation) completed. ST to Tx (treat) 3 x wk/4 wks (three times per week for four weeks) Continue pt (patient) on NPO (nothing by mouth)..." Medical record review of the care plan updated April 6, 2011, revealed "...encourage fluids with all accepted food related activities and when visiting in room...encourage po (by mouth) fluids with meals, hydration passes and prn (as needed)...keep water pitcher within reach..." Observation on April 18, 2011, at 12:25 p.m., and April 19, 2011, at 3:55 p.m., revealed the resident in the room with no food or water pitcher present. Interview with Registered Nurse #2 on April 18, 2011, at 3:58 p.m., in the Minimum Data Set office, confirmed the care plan had not been updated since the April 10, 2011, readmission to address the NPO status.	F 280	How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 1. The Director of Nursing/Assistant Director of Nursing will conduct random weekly audits comparing the care plan to the current physician's orders. The audits will continue weekly times one month then monthly thereafter or until substantial compliance is achieved. Trends, patterns, or problems identified will be reviewed in the Quality Assurance meeting held at least on a quarterly basis. DISCLAIMER: "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth of the statement of deficiencies. This plan is prepared and/or executed solely because it is required."	5/27/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, laboratory data review, laboratory calendar review, and interview, the facility failed to	F 281	 Administrator Date 5/3/11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2011
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NAME OF PROVIDER OR SUPPLIER

ETOWAH HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

409 GRADY ROAD, PO BOX 957

ETOWAH, TN 37331

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F 281	<p>Continued From page 7</p> <p>administer a tube feeding as ordered by the physician for one resident (#5); failed to clarify the physician laboratory order and failed to obtain laboratory studies as ordered by the physician for one resident (#11) of twenty residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on November 5, 2010, and readmitted on April 10, 2011, with diagnoses including Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Bronchitis, Diabetes Mellitus, and Dysphagia.</p> <p>Medical record review of a physician's order dated April 10, 2011, revealed "...Glucerna (tube feeding formula) 240 ml (milliliters) bolus feeding every 4 hours via PEG (Percutaneous Endoscopic Gastrostomy) tube..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on April 18, 2011, at 3:38 p.m., at the 100/200 nursing station, confirmed the LPN administered "...Glucerna 1.5 calorie since (LPN) got here Saturday..." Further interview confirmed the LPN had not followed the physician order to administer Glucerna.</p> <p>Interview with the Director of Nursing (DON) , in the DON's office, on April 18, 2011, at 3:40 p.m., confirmed the facility had not followed the physician order to administer Glucerna.</p> <p>Interview with LPN #2, on April 19, 2011, at 8:41 a.m., at the 100/200 nursing station, confirmed the LPN had administered Glucerna 1.5 calorie formula on Friday. Further interview confirmed the LPN had failed to follow the physician order to administer Glucerna.</p>	F 281	<p>281</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The physician of Resident #5 was notified on 4/18/2011 by the charge nurse/licensed practical nurse. A new order was obtained for Glucerna 1.5 to be given as the bolus peg tube feeding to meet the nutritional requirements of the resident. A charge nurse notified the physician of Resident # 11 on April 19, 2011 that the lab was not drawn and a clarification order was received for the lab to be drawn on April 22, 2011 and three months after obtaining the baseline labs. A CMP, TSH, HgA1C was drawn on April 22, 2011 as ordered and the physician was notified of the results. The physician reviewed the results and gave no new orders.</p>	5/27/11

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F 281	<p>Continued From page 7</p> <p>administer a tube feeding as ordered by the physician for one resident (#5); failed to clarify the physician laboratory order and failed to obtain laboratory studies as ordered by the physician for one resident (#11) of twenty residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on November 5, 2010, and readmitted on April 10, 2011, with diagnoses including Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Bronchitis, Diabetes Mellitus, and Dysphagia.</p> <p>Medical record review of a physician's order dated April 10, 2011, revealed "...Glucerna (tube feeding formula) 240 ml (milliliters) bolus feeding every 4 hours via PEG (Percutaneous Endoscopic Gastrostomy) tube..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on April 18, 2011, at 3:38 p.m., at the 100/200 nursing station, confirmed the LPN administered "...Glucerna 1.5 calorie since (LPN) got here Saturday..." Further interview confirmed the LPN had not followed the physician order to administer Glucerna.</p> <p>Interview with the Director of Nursing (DON) , in the DON's office, on April 18, 2011, at 3:40 p.m., confirmed the facility had not followed the physician order to administer Glucerna.</p> <p>Interview with LPN #2, on April 19, 2011, at 8:41 a.m., at the 100/200 nursing station, confirmed the LPN had administered Glucerna 1.5 calorie formula on Friday. Further interview confirmed the LPN had failed to follow the physician order to administer Glucerna.</p>	F 281	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>Residents who receive a tube feeding or have orders for lab work has the potential to be affected by the same deficient practice. The Director of Nursing will provide in-service education on May 13, 2011 that will include administering the correct type and strength of a tube feeding according to physician order and the importance of performing lab work according to MD orders. The in-service education will also include obtaining a date from the physician when the lab is to be drawn. The nurse managers will review current orders for residents receiving tube feedings. The physician's order will be matched against the medication administration record to check type of feeding as well as strength of feeding. A nurse manager will routine lab orders and review telephone orders for assigned residents for the past 60 days for compliance with orders for labs.</p>	5/27/11

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Continued From page 8

Resident #11 was admitted to the facility on February 1, 2011, with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Stage III Chronic Renal Failure, and Diabetes Mellitus.

Medical record review of a physician's telephone order dated March 24, 2011, revealed "...lipid profile + (and) CMP (Comprehensive Metabolic Profile) q (every) 6 mo (months)...Digoxin level q 6 mo...TSH (Thyroid Stimulating Hormone) yrly (yearly)...HgbA1C (measure blood glucose level over three month period) q 3 mo..."

Medical record review of the laboratory (lab) data revealed no lab results for March 24, 2011.

Medical record review of the "Lab Calendar" revealed on May 6, 2011 PT/INR, BMP, CBC, Lipid profile, CMP, Digoxin level, TSH and HgbA1C were scheduled to be drawn.

Interview with Licensed Practical Nurse (LPN) #3 on April 19, 2011, beginning at 3:18 p.m., in the Director of Nursing's office, with the Director of Nursing present, confirmed LPN #3 "...took it on myself to schedule (the lab) on May 6, 2011, and should have called the doctor to clarify (the order)..." Further interview confirmed no labs had been drawn based on the March 24, 2011, telephone order.

Interview with the DON, in the Social Service office, April 20, 2011, at 8:15 a.m., confirmed the facility had not followed the March 24, 2011, physician order. Further interview and record review of a phone order dated April 19, 2011, confirmed the physician reordered the labs to be

F 281

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:

1. The Director of Nursing will provide in-service education on May 13, 2011 to the licensed staff on the importance of administering a tube feeding per physician's order and obtaining a date the doctor wants the lab work done with the original order. A post-test will be given after the in-service to promote competency.

2. New licensed employees will receive education on administering tube feeding correctly according to order/strength and obtaining lab work orders with the date the physician wants the lab work done during their orientation period.

3. A nurse manager will maintain a lab flow sheet for assigned residents that will include when the lab order was received, when the lab was drawn, and any follow up required after physician notification has been made aware of the lab results. Telephone orders will be reviewed by the nurse managers and added to the flow sheet for follow-up.

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F 281

Continued From page 8

F 281

5/27/11

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Medical record review of a physician's telephone order dated March 24, 2011, revealed "...lipid profile + (and) CMP (Comprehensive Metabolic Profile) q (every) 6 mo (months)...Digoxin level q 6 mo...TSH (Thyroid Stimulating Hormone) yrlly (yearly)...HgbA1C (measure blood glucose level over three month period) q 3 mo..."

Medical record review of the laboratory (lab) data revealed no lab results for March 24, 2011.

Medical record review of the "Lab Calendar" revealed on May 6, 2011 PT/INR, BMP, CBC, Lipid profile, CMP, Digoxin level, TSH and HgbA1C were scheduled to be drawn.

Interview with Licensed Practical Nurse (LPN) #3 on April 19, 2011, beginning at 3:18 p.m., in the Director of Nursing's office, with the Director of Nursing present, confirmed LPN #3 "...took it on myself to schedule (the lab) on May 6, 2011, and should have called the doctor to clarify (the order)..." Further interview confirmed no labs had been drawn based on the March 24, 2011, telephone order.

Interview with the DON, in the Social Service office, April 20, 2011, at 8:15 a.m., confirmed the facility had not followed the March 24, 2011, physician order. Further interview and record review of a phone order dated April 19, 2011, confirmed the physician reordered the labs to be

4. The Nurse managers will check physician's orders each month with the medication administration record to verify that correct tube feeding is being administered.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
The Director of Nursing/Assistant Director of Nursing will perform random weekly audits of tube feeding orders and completion of ordered lab work. Audits will continue weekly times one month then will be done monthly or until substantial compliance is reached. Trends, patterns, or problems identified will be reviewed in the Quality Assurance meeting held at least on a quarterly basis.

DISCLAIMER: "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth of the statement of deficiencies. This plan is prepared and/or executed solely because it is required."

Barthe E / 15 5/3/11
Administrator Date

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F 281	Continued From page 9	F 281		
F 315 SS=D	drawn on April 22, 2011, and then as specified. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to provide an individualized toileting plan for one (#2) resident of twenty residents reviewed. The findings included: Resident #2 was admitted to the facility on March 24, 2011, with diagnoses including Fractured Right Femur, Chronic Kidney Disease, Hypertension, and Congestive Heart Failure. Medical record review of the Minimum Data Set dated March 30, 2011, revealed the resident was always incontinent of urine. Medical record review of the Bowel and Bladder Assessment dated March 24, 2011, revealed the resident was a candidate for a toileting schedule (timed voiding).	F 315	F 315 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident # 2 was placed on an individualized toileting program based on her incontinence assessment on April 29, 2011 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Incontinent residents have the potential to be affected by the same deficient practice. The Director of Nursing will provide in-service education on May 13, 2011 to the licensed staff on the importance of establishing a bladder management program for each resident based on condition, incontinence pattern, and incontinence supplies needed for each individual resident. The nurse managers will reassess incontinent residents for the need of an individualized toileting program.	5/27/11

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F 281	Continued From page 9	F 281		
F 315	drawn on April 22, 2011, and then as specified.	F 315		
SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER			
	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.		What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:	5/29/11
	This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to provide an individualized toileting plan for one (#2) resident of twenty residents reviewed.		1. The Director of Nursing will provide in-service education on May 13, 2011 to the licensed staff on the importance of establishing a bladder management program for each resident based on condition, incontinence pattern, and incontinence supplied needed for each individual resident. A post test will be given after the in-service to promote competency.	
	The findings included:		2. New licensed employees will receive education on bladder tracking and bladder management during their orientation period.	
	Resident #2 was admitted to the facility on March 24, 2011, with diagnoses including Fractured Right Femur, Chronic Kidney Disease, Hypertension, and Congestive Heart Failure.		3. Upon admission, a licensed nurse will complete a bowel and bladder assessment. Based on the results of the assessment, an individualized toileting plan will be established for the resident and added to their plan of care.	
	Medical record review of the Minimum Data Set dated March 30, 2011, revealed the resident was always incontinent of urine.		4. If a resident has a significant change in condition, the bowel and bladder assessment will be updated by a licensed nurse and an individualized toileting program will be established for the resident and added to their plan of care.	
	Medical record review of the Bowel and Bladder Assessment dated March 24, 2011, revealed the resident was a candidate for a toileting schedule (timed voiding).			

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F 315 Continued From page 10
Review of facility policy, Bladder Management (Training) Program, revealed "...Observe and record the present voiding pattern to establish a definite schedule. This should be done for two to three weeks or longer, if necessary, to establish a pattern...When usual voiding times have been established, arrange for resident to void one-half hour prior to his/her established time...Record all results and incorporate the individual program in the resident care plan..."

Observation on April 18, 2011, at 3:35 p.m., revealed the resident seated in a wheelchair in the dining room.

Interview on April 20, 2011, at 10:00 a.m., with RN (Registered Nurse) #1, at the nursing station, confirmed an individualized toileting plan had not been established for the resident.

Interview on April 20, 2011, at 10:15 a.m., with CNA (certified nursing assistant) #1 and CNA #2 (assigned to the resident's hall) confirmed the CNA's offer to toilet the resident every two hours, but not on a specific schedule.

F 371 483.35(i) FOOD PROCURE,
SS=F STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 315

5. The nurse managers will maintain an incontinence log of the assigned resident indicating the date the assessment was completed and what interventions were put into place. The resident's response to the program will be documented on the incontinence log, and interventions will be added to the care plan.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Director of Nursing/Assistant Director of Nursing will perform random weekly audits of the incontinence log and current residents on bladder management. The audits will continue weekly times one month then will be conducted monthly until substantial compliance has been reached. Results of the audits will be reviewed at the Quality Assurance meeting that is held at least quarterly.

F 371

5/27/11

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F 371	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, dish machine manufacturer's temperature recommendation review, and interview, the facility failed to wash dishes at 140 degrees Fahrenheit; and failed to maintain sanitary conditions in the dish room and the pot and pan areas.</p> <p>The findings included:</p> <p>Observation on April 18, 2011, at 1:20 p.m., in the dish room, with the Certified Dietary Manager (CDM) present, revealed the dish machine was in operation. Further observation revealed one dietary staff member working the dirty and clean side of the machine. Further observation revealed the employee opened the dish machine, pushed a dirty rack of dishes into the machine and the dirty rack came in contact with the clean rack of dishes inside the machine. Further observation revealed the two clean racks of dishes inside the machine were ejected from the machine by pushing two dirty racks of dishes into the machine. Further observation revealed the employee closed the machine door, went to the clean side of the machine, without removing soiled gloves and washing hands, and lifted the two clean racks onto the lip of the drain board. Further observation revealed the employee went to the dirty side of the machine and filled two racks with dirty dishes. Further observation revealed the employee repeated the process of opening the machine, pushing a dirty rack into a clean rack to eject the clean dishes, and without removing soiled gloves and washing hands, lifted the clean racks onto the drain board lip.</p> <p>Observation, in the presence of the CDM, of the</p>	F 371	<p>DISCLAIMER: "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth of the statement of deficiencies. This plan is prepared and/or executed solely because it is required."</p> <p><i>Barthe E. Note</i> 5/3/11 Administrator Date</p> <p>F 371 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the deficient practice; the dish machine was brought up to 140 degrees and the dishes were rewashed by the dietary aid/dishwasher. Education was given to the dietary employee/dishwasher by the dietary manager about checking for the proper temperature of the dish machine prior to putting dishes into the machine and the need to wash hands between adding dirty dishes and removing clean dishes from the machine. The fan was cleaned by the dietary aid on 4/19/2011 and placed on a weekly cleaning schedule by the Dietary Manager.</p>	5/3/11	

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ETOWAH, TN 37331

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F 371	<p>Continued From page 12</p> <p>two cycles of the dish machine revealed wash temperatures of 132 and 136 degrees Fahrenheit (F).</p> <p>Review of the dish machine manufacturer's recommendations, posted onto the body of the machine, revealed the wash and rinse temperature recommendation was 140 degrees F.</p> <p>Interview on April 18, 2011, at 1:20 p.m., with the dietary employee working the dish machine, in the dish room, revealed the dish machine had been in operation for the past twenty minutes.</p> <p>Interview, with the CDM, on April 18, 2011, confirmed the wash temperatures of the two cycles of the dish machine were below the manufacturer's recommended 140 degrees F. Further interview confirmed the dietary staff member working in the dish room had pushed the dirty rack of dishes into the clean rack of dishes in two cycles of the machine. Further interview confirmed the dietary staff member working in the dish room had not removed the soiled gloves and washed their hands before lifting the clean rack of dishes onto the drain board lip in two cycles of the machine.</p> <p>Observation on April 18, 2011, at 1:12 p.m., revealed a large black floor fan, not in operation, with debris built-up on the grate and blades pointed at the clean pot and pans on the drain board of the three compartment sink.</p> <p>Observation on April 19, 2011, at 8:27 a.m., revealed the large black fan in operation and blowing directly at the pot and pans drying on the drain board of the three compartment sink.</p>	F 371	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents have the potential to be affected by the same deficient practice. Education was given to the dietary employee by the dietary manager on 4/19/2011 on the importance of checking for the proper temperature of the dish machine prior to putting dishes into the machine and the need to wash hands between adding dirty dishes and removing clean dishes from the machine; The dish machine was brought up to 140 degrees and the dishes were rewashed by the dietary aid/dishwasher. The fan was cleaned by the dietary aid on 4/19/2011 and placed on a weekly cleaning schedule by the Dietary Manager.</p>	5/27/11

MAY 06 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2011
NAME OF PROVIDER OR SUPPLIER ETOWAH HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page 13 Further observation of the CDM turning off the fan revealed the grate and blades had a build-up of debris. Interview on April 19, 2011, at 8:27 a.m., with the CDM, by the three compartment sink, confirmed the large black fan grate and blades had a build-up of debris and was blowing directly onto the clean pots and pans in the three compartment sink drain board.	F 371	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <p>1. The Dietary Manager provided in-service education to the dietary employees on 4/20/2011. The in-service education included checking the dish machine temperature prior to adding dishes to make sure it is at least 140 degrees, monitoring the machine throughout the washing cycle to make sure that 140 degrees is maintained throughout the washing cycle, and the need for hand washing between putting dirty dishes through the machine and pulling clean dishes out of the machine. In-service education also included completing the dish machine temperature log prior to each use, the importance of washing hands between touching dirty and clean dishes, and the new cleaning schedule for the fan.</p>		5/27/11

MAY 06 2011

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2011
NAME OF PROVIDER OR SUPPLIER ETOWAH HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An annual survey and complaint investigation #27025 and #27888, were completed on April 18-20, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.		N 000	<p>2. New dietary employees will receive education during their orientation period on required temperatures for the dish machine, the importance of maintaining 140 degrees throughout the washing cycle, hand washing, and cleaning schedules for the fan.</p> <p>3. The dietary aid assigned to be the dishwasher will log the temperature of the dish machine before each use. Once the temperature of 140 degrees has been checked and logged, dishes will be placed in the dish machine. During the dishwashing cycle, the dietary aid will make sure the machine maintains the temperature of 140 degrees until the washing cycle is completed. In the event the temperature is less than 140 degrees on the initial temperature check or fails to maintain 140 degrees during the wash cycle, the dietary aid will notify the dietary manager along with the maintenance supervisor.</p>	5/27/11

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

TNDS11

If continuation sheet 1 of 1

MAY 06 2011

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2011
NAME OF PROVIDER OR SUPPLIER ETOWAH HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331		
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N 000	Initial Comments An annual survey and complaint investigation #27025 and #27888, were completed on April 18-20, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.		N 000	<p>4. The Dietary Manager will perform random checks at least 5 times per week of the temperature log and of the dish machine temperature prior to use for one month. After one month, the checks will be completed weekly for two months or until substantial compliance is achieved. The Dietary Manager will record the temperatures found on the random checks on a log. The log will also include random checks of employee hand washing and the cleanliness of the fan.</p> <p>5. Any deficient practice will have corrective action taken at time of discovery.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Dietary Manager will review the audit logs for any trends or patterns. Problem areas will be reviewed at the Quality Assurance meeting held at least on a Quarterly basis.</p>	5/27/11

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If continuation sheet 1 of 1

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